DRUG & ALCOHOL FINDINGS *Review analysis*

This entry is our analysis of a review or synthesis of research findings added to the Effectiveness Bank. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

▶ Positive regard and psychotherapy outcome: a meta-analytic review.

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Psychotherapy: 2018, 55(4), p. 411–423.

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Findings amalgamated for the American Psychological Association show that across psychotherapy studies, outcomes improve the more therapists consistently demonstrate warmth and high regard for their clients – given the stigma and low regard attached to dependent substance use(rs), findings with important implications for promoting recovery.

SUMMARY [Though not specific to clients with drug and alcohol problems, the principles derived from this review of psychotherapy studies are likely to be applicable, partly because severe substance use problems generally form part of a complex of broader psychosocial problems. This review updates an earlier version also in the Effectiveness Bank.]

The featured review is one of several in a special issue of the journal *Psychotherapy* devoted to features of the therapist-client relationship related to effectiveness, based on the work of a task force established by the American Psychological Association. This particular review analysed findings relating psychotherapy outcomes to the degree to which therapists are consistently warm and show high regard for their clients – sometimes termed 'therapist affirmation', 'non-possessive warmth' or, as in this review, 'positive regard'.

Positive regard was one of a trio of interpersonal qualities posited as essential to therapeutic success in 1957 in a classic paper by the therapist Carl Rogers (1 2). The other two, often termed congruence or genuineness and empathy, are reviewed in other papers. Rogers' paper fostered the view that the therapist-client relationship *per se* was the critical determinant of therapeutic success, rather than the therapist's technical expertise in, for example, choice and timing of interventions.

Key points
From summary and commentary

Commissioned by a task force of the American Psychological Association, this review amalgamated findings relating psychotherapy outcomes to the degree to which therapists are consistently warm and show high regard for their clients, termed 'positive regard'.

The strength of the link between positive regard and outcomes was small but statistically significant, indicating that better outcomes can be expected when the therapist affirms the client and conveys their unconditional warmth and liking.

This link may or may not be causal. Nevertheless, the safest stance is to presume it is – that how the therapist is and behaves affects how well their clients do, and does so partly via their positive regard for the client.

The featured review incorporated a meta-analysis amalgamating results from relevant studies to estimate the overall strength of the link between positive regard and the outcomes of psychotherapy, and to be able to probe for influences on the strength of the link. The strengths of the links were expressed as effect sizes. This metric can be seen as indicating how influential positive regard was if in these studies it had caused (and not just been associated with) better outcomes.

The analysis included studies of individual, family, or group psychotherapy of adults and/or (in a

fifth of studies) under-18s which measured both patient progress and positive regard, and reported on their relationships in a way which enabled results to be aggregated with those from other studies. With minor exceptions, all the studies had to have been reported in English. In only two of the resulting 64 studies did the therapist alone assess the degree of positive regard. In just under 60% of studies it was rated by the client and in just over a quarter by a third party. Three-quarters of the studies had been conducted in the USA.

Main findings

Across the 64 studies of in total 3,528 patients, the strength of the link between positive regard and therapy outcomes equated to a small but statistically significant effect size of 0.28, indicating that better outcomes can be expected when the therapist affirms the client and conveys their unconditional warmth and liking. The effect size increased to a small-to-medium 0.36 when the analysis took into account the fact that some studies reported several estimates of the strength of the link between positive regard and therapy outcomes, violating the assumption that all 369 estimates were independent of each other. There remained, however, the possibility that studies which found smaller or non-significant links had more often been omitted from the analysis than those which found stronger links, inflating the estimates.

The strength of the regard–outcomes relationship varied across studies more than would be expected by chance. Several factors were significantly associated with the differences. Positive regard was more strongly associated with psychotherapy outcomes in studies of individual rather than group or family therapy, in an outpatient rather than inpatient setting, with clients presenting with depression, anxiety or other disorders affecting the patient's mood as opposed to severe mental illness [affecting their perceptions of reality], when outcome had been assessed via measures of global or overall symptomatology rather than specific indices of depression or anxiety, and when the therapist was a trainee versus not a trainee. However, these factors overlapped. When this overlap was taken into account, as a whole they still accounted for some of the variation in the strength of the regard–outcomes link, but individually none remained significantly associated with the differences.

Notably lacking from the research were studies exploring how the impact of positive regard might vary with or depend on other therapist attitudes and behaviours. For example, positive regard might be significantly associated with outcomes only when therapists are relatively non-directive in their relationships with their clients. Also sparse were studies which might shed light on whether positive regard is perceived more strongly by clients treated by therapists from a similar background or with whom they share other characteristics.

Measuring positive regard

The "Level of Regard" scale of the Barrett-Lennard Relationship Inventory is the most widely used measure of positive regard. Its questions are based on the concepts promoted by sseminal therapist Carl Rogers (1 2). Some of the statements which clients rate from strongly agreeing to strongly disagreeing are reproduced below:

- "She respects me as a person."
- "She is friendly and warm toward me."
- "I feel appreciated by her."
- "I feel that she disapproves of me." (reverse scored)
- "She is impatient with me." (reverse scored)
- "At times she feels contempt for me." (reverse scored)

Practice recommendations

The therapist's ability to convey positive regard is significantly associated with therapeutic success. It is a small but important part of the equation linking the process of therapy to its outcomes. Extrapolating from the data, the reviewers made the following recommendations for clinical practice:

- Therapists should embody and express positive regard for their patients, not least because there is virtually no research-driven reason to withhold this kindness. At a minimum, it 'sets the stage' for other active ingredients in patient progress and, at least in some cases, may be sufficient to effect positive change.
- Keep in mind that affirming patients may serve many valuable functions. It may strengthen the client's sense of self or agency and belief in their capacity to be engaged in an effective relationship, reinforce engagement in the therapeutic process (including difficult self-disclosures), and facilitate psychological growth and resilience.

• Therapists cannot be content with just *feeling* good about their patients, but should ensure they communicate a caring, respectful, positive attitude that affirms a client's sense of worth. This does not mean a stream of compliments or a gushing of positive sentiment which may overwhelm or even terrify some clients. To many, if not most clients, the conviction that 'My therapist really cares about me' is likely to be critical, especially in times of stress.
• Convey regard through multiple channels, including offering reassuring, caring words, creating positive narratives, active listening, flexibility in scheduling, speaking in a gentle tone of voice, establishing responsive eye contact, and maintaining positive body language.
• Therapists are advised to monitor their expressions of positive regard and adjust these as a function of particular patients and specific situations. Therapists vary in the extent to which they convey positive regard, and clients vary in the extent to which they need, elicit, and benefit from it. It seems likely that the inevitable ruptures in the therapeutic alliance result not only from a therapist's technical errors, but also from their occasional inability to demonstrate minimal levels of positive regard.
• Provide clinical supervision for therapists that includes investigations of the specific ways in which their acceptance, liking, and caring for their clients have been conveyed (or not) in sessions, and the clinical consequences of these actions.

FINDINGS COMMENTARY The reviewers' practice recommendations are based on the possibility of a causal link between positive regard and how well patients progress, which can be leveraged by the therapist to augment that progress. In other words, the proposition is that how the therapist behaves affects how well their patients do, and does so partly via the perceptions they generate in the client that they like and appreciate them, validating them as an attractive and valued human being.

Given the nature of the studies which supported these implications, causality cannot be considered proven (▸ below), but for at least two reasons it seems likely. First is the consistency of the association between positive regard and outcomes – universally positive (if sometimes very small and non-significant) across all 64 studies. Second is the plausibility of the proposition that among patients feeling very bad about themselves, contradicting these feelings by showing they are appreciated and liked and affirming their value, will have a positive impact. Supporting this proposition is the finding that the regard–outcomes link was strongest amongst patients whose problem was primarily or partly that they did feel bad about themselves and the world in general. Such mood disorders are the main psychopathology commonly associated with dependent substance use, which itself can generate feelings of worthlessness, as can any associated crime, breakdown of family relationships, stigma, and loss of status in society including one's freedom, independence, and right to parent one's own children.

Additionally, there seems little or nothing to lose (none of the studies found a negative regard–outcomes relationship) and possibly much to gain from evidencing positive regard, nothing to gain and possibly much to lose from failing to do so, and common humanity demands a positive attitude to troubled individuals who have come to you for help. As the reviewers comment, findings such as theirs "provide a theoretical justification for being kind to one's patients". The implication is that therapists and their trainers and supervisors should presume a causal relationship, and seek to magnify the patient's genuine perceptions that the therapist is not judging or denigrating them for their problems, but positively appreciates and likes them in their core as a human being, regardless of what they may say or do.

Reinforcing the presumption of causality is the fact that some of the conditions associated with a stronger regard–outcomes relationship make sense from this perspective. Already referred to is the stronger association among patients with disorders of mood. It makes sense too that the link would be stronger in a one-to-one therapist–client relationship, and when this relationship is not overshadowed by an all-embracing residential setting.

Positive regard and substance use interventions

In the substance use sector, positive regard has most often been studied in the context of brief interventions based on the motivational interviewing style of counselling. In this tradition, positive regard comes closest to being captured by global “acceptance” of the patient or the count of comments demonstrating “affirmation”, such as when the therapist says something positive or complimentary to and about the client – perhaps appreciation, confidence in their abilities or intentions, or comments reinforcing the client’s actions or statements. In the same counselling style, eliciting client comments indicative of a desire, intention, ability, or commitment to change in the desired direction – so called ‘change talk’ – is seen as the crucial precursor to actual change.

A study of brief motivational counselling for US college students mandated into treatment because of drinking problems, found that affirmation was the only specific therapist behaviour followed by more change talk and less of the opposite – comments indicative of non-change. According to motivational interviewing theory, this places affirmation as a key mechanism for effecting desired changes in behaviour. It is not the only study of motivational interviewing in which affirmation or acceptance have been linked to better substance use outcomes, though such findings are not universal and the nature of this link is unclear.

In the case of affirmation, such a link emerged in a study of brief motivational counselling of hazardous drinkers identified at a Swiss emergency department, when the frequency of affirming comments strongly predicted the frequency of heavy drinking episodes in the last month of the 12-month follow-up. After the results were adjusted for the age, sex and severity of drinking of the patients, this association remained, but was attenuated and missed being statistically significant at the conventional level, though it was a notable trend. The suggestion was that it and other findings in the study might have been partly due to counsellors responding positively to patients who were showing signs of heeding the counselling – a reverse causality in which patient change causes affirmation, rather than the other way round.

From the same study, another analysis focused on what might have made individual counsellors more or less effective at reducing drinking. Among the counsellor behaviours evident in their sessions with hazardous drinking emergency patients, the degree of acceptance of their patients was strongly and positively related to how much the patients had reduced their drinking by the final month of the 12-month follow-up. For example, of the five counsellors, patients of the one who had evidenced the greatest degree of acceptance had reduced their drinking by about seven glasses a week, and those of the one who had evidenced the least had increased by about 13 glasses.

Among a complex of other similar variables, the global impression of the degree to which the counsellor demonstrated acceptance of the patient also emerged as possibly influential in a study of the counselling of heavy drinkers among young male Swiss army conscripts. It set out to reveal the impact of the counsellors rather than the intervention by recruiting 18 who differed widely in professional status, clinical experience, and experience of motivational interviewing. The more experienced counsellors were better at reducing drinking, but only because experience was associated with more advanced motivational interviewing skills, an amalgam of demonstrating acceptance of and empathy with the client and embodying the collaborative spirit of the approach. However, when it came to specific counsellor behaviours, so-called ‘complex reflections’ – the times when the counsellor reflected back the client’s feelings or comments, but with a spin which extended or deepened their meaning – seemed particularly important. When these formed a relatively small portion of all the reflections whether simple or complex, the brief intervention made no difference to drinking; when a larger portion, drinking was reduced. In contrast, simply accreting more of the other responses considered compatible with motivational interviewing – including affirmation – actually seemed counterproductive. Frequent

interjections by the counsellor which conveyed support, affirmation, straightforwardly reflected back the client's comments, and so on, seemed fine, but when these became *very, very* frequent, something was happening to make the session ineffective.

A similarly surprising finding emerged from another study of the counselling of heavy drinkers among young male Swiss army conscripts, where a bundle of motivational interviewing behaviours dominated by affirmation was *less* likely to be followed by the desired change talk. However, this finding was based on a rather unsophisticated understanding of affirmation, which included (for example) thanking the client for coming at the start and end of the session. Again, in this study reflective listening seemed the key counsellor behaviour promoting change talk, as it has in other studies.

Not *necessarily* causal

Though this account is plausible, and it would be safe to assume a causal link and probably unsafe not to, such a link could not be established by the types of studies included in the analysis. Generally these documented the development of client or observer perceptions of positive regard in the natural course of therapy, and related these perceptions to outcomes. The review identified no studies which had randomly allocated patients to therapies during which positive regard was deliberately generated, versus deliberately withheld or replaced by negative regard, and such studies would almost certainly be considered unethical. But without these studies, the possibilities cannot be ruled out that (for example) patients who were going to do well in any event were more likely to feel that the therapist was on their side and liked them, and/or that such feelings were partly due to the fact that patients were *already* doing well and had a sunnier outlook on life including themselves and their therapists, or that therapists more capable of generating these feelings were also more competent in other ways. In these scenarios, positive regard would remain *associated* with better outcomes, but not because it helped *cause* them.

As they are added to the Effectiveness Bank, listed below will be analyses of the remaining reviews commissioned by the American Psychological Association task force.
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Thanks for their comments on this entry in draft to Richard Velleman of the Sangath Community Health NGO in India and Emeritus Professor of Mental Health Research at the University of Bath in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 18 December 2018. First uploaded 08 December 2018

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